

		FOR OHF USE					

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0019166</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																									
<b>Facility Name:</b> <u>Pleasant Meadows Christian Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 1999</u> to <u>June 30, 2000</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
<b>Address:</b> <u>400 West Washington</u> <u>Chrisman</u> <u>61924</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
<b>County:</b> <u>Edgar</u>																											
<b>Telephone Number:</b> <u>217-269-2396</u> <b>Fax #</b> ( <u>    </u> )																											
<b>IDPA ID Number:</b> <u>37-0841562001</u>																											
<b>Date of Initial License for Current Owners:</b> <u>1974</u>																											
<b>Type of Ownership:</b>																											
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>																											
<input checked="" type="checkbox"/> Charitable Corp.																											
<input type="checkbox"/> Trust																											
<b>IRS Exemption Code</b> <u>501(C)3</u>																											
<input type="checkbox"/> <b>PROPRIETARY</b>																											
<input type="checkbox"/> Individual																											
<input type="checkbox"/> Partnership																											
<input type="checkbox"/> Corporation																											
<input type="checkbox"/> "Sub-S" Corp.																											
<input type="checkbox"/> Limited Liability Co.																											
<input type="checkbox"/> Trust																											
<input type="checkbox"/> Other <u>                    </u>																											
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>William O. Buskirk</u> <b>Telephone Number:</b> <u>217-525-1111</u>		<table border="1"> <tr> <td rowspan="2"> <b>Officer or Administrator of Provider</b> </td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) <u>Mark Havrilka</u></td> </tr> <tr> <td rowspan="4"> <b>Paid Preparer</b> </td> <td colspan="2">(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td colspan="2">(Signed) _____</td> </tr> <tr> <td colspan="2">(Date) _____</td> </tr> <tr> <td colspan="2">(Print Name and Title) <u>William O. Buskirk, CPA</u></td> </tr> <tr> <td colspan="2">           (Firm Name &amp; Address) <u>Eck, Schafer &amp; Punke, LLP</u>  <u>600 East Adams Springfield, IL 62701-1624</u> </td> <td></td> </tr> <tr> <td colspan="2">           (Telephone) <u>217-525-1111</u> <b>Fax #</b> <u>217-525-1120</u> </td> <td></td> </tr> <tr> <td colspan="3"> <b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> </td> <td> <b>Phone # (217) 782-1630</b> </td> </tr> </table>		<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mark Havrilka</u>		<b>Paid Preparer</b>	(Title) <u>Chief Financial Officer</u>		(Signed) _____		(Date) _____		(Print Name and Title) <u>William O. Buskirk, CPA</u>		(Firm Name & Address) <u>Eck, Schafer &amp; Punke, LLP</u> <u>600 East Adams Springfield, IL 62701-1624</u>			(Telephone) <u>217-525-1111</u> <b>Fax #</b> <u>217-525-1120</u>			<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>			<b>Phone # (217) 782-1630</b>
<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____																									
	(Type or Print Name) <u>Mark Havrilka</u>																										
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	(Signed) _____																										
	(Date) _____																										
	(Print Name and Title) <u>William O. Buskirk, CPA</u>																										
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## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Pleasant Meadows Christian Village# 0019166 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds 12/22/99

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	109	38,154	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	109	38,154	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	8,849	6,725		15,574	8
9	SNF/PED					9
10	ICF	9,039	7,537		16,576	10
11	ICF/DD					11
12	SC	1,065	2,697		3,762	12
13	DD 16 OR LESS					13
14	TOTALS	18,953	16,959		35,912	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 94.12%

D. How many bed-hold days during this year were paid by Public Aid?

133 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☒ NO ☐H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☒ NO ☐I. On what date did you start providing long term care at this location?  
Date started 1974

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒K. Was the facility certified for Medicare during the reporting year?  
YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_Medicare Intermediary N / A

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/00 Fiscal Year: 06/30/00

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	159,754	15,197	7,715	182,666		182,666		182,666		1
2	Food Purchase		178,699		178,699		178,699	(57)	178,642		2
3	Housekeeping	82,311	18,063		100,374		100,374		100,374		3
4	Laundry	56,622	17,227		73,849		73,849		73,849		4
5	Heat and Other Utilities			146,699	146,699		146,699	(4,489)	142,210		5
6	Maintenance	40,149		49,281	89,430		89,430	5,543	94,973		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	338,836	229,186	203,695	771,717		771,717	997	772,714		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,800	1,800		1,800		1,800		9
10	Nursing and Medical Records	1,333,373	71,081	13,124	1,417,578		1,417,578		1,417,578		10
10a	Therapy			24,420	24,420		24,420		24,420		10a
11	Activities	33,301	1,998	3,918	39,217		39,217		39,217		11
12	Social Services	64,144			64,144		64,144	(796)	63,348		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,430,818	73,079	43,262	1,547,159		1,547,159	(796)	1,546,363		16
	<b>C. General Administration</b>										
17	Administrative	73,364	3,313	139,980	216,657		216,657	(110,565)	106,092		17
18	Directors Fees										18
19	Professional Services			721	721		721	15,751	16,472		19
20	Dues, Fees, Subscriptions & Promotions			37,036	37,036		37,036	(2,357)	34,679		20
21	Clerical & General Office Expenses	56,729	10,370	26,766	93,865		93,865	20,639	114,504		21
22	Employee Benefits & Payroll Taxes			273,917	273,917		273,917	6,366	280,283		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,031	7,031		7,031	2,120	9,151		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			11,672	11,672		11,672	1,164	12,836		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	130,093	13,683	497,123	640,899		640,899	(66,882)	574,017		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,899,747	315,948	744,080	2,959,775		2,959,775	(66,681)	2,893,094		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Pleasant Meadows Christian Village

#0019166

Report Period Beginning:

July 1, 1999

Ending:

June 30, 2000

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			126,827	126,827		126,827	8,315	135,142			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			252	252		252		252			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			127,079	127,079		127,079	8,315	135,394			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	18,561	1,325		19,886		19,886		19,886			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,232	57,232		57,232		57,232			42
43	Other (specify):* Congregate			111,740	111,740		111,740		111,740			43
44	<b>TOTAL Special Cost Centers</b>	18,561	1,325	168,972	188,858		188,858		188,858			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,918,308	317,273	1,040,131	3,275,712		3,275,712	(58,366)	3,217,346			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

## STATE OF ILLINOIS

Page 5

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning:

July 1, 1999

Ending:

June 30, 2000

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(57)	2		4
5 Telephone, TV & Radio in Resident Rooms	(5,062)	5		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	1,951	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds	146	21		11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(3,188)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(369)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (6,579)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(51,787)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (51,787)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (58,366)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
	Reference		
1	Vending Machine	\$ 427	17
2	Activity income	(796)	12
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90	Total	(369)	

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning:

July 1, 1999

Ending:

June 30, 2000

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(57)	0	0	0	0	0	0	0	0	0	0	(57)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,062)	573	0	0	0	0	0	0	0	0	0	(4,489)	5
6	Maintenance	0	5,543	0	0	0	0	0	0	0	0	0	5,543	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,119)</b>	<b>6,116</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>997</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(796)	0	0	0	0	0	0	0	0	0	0	(796)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(796)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(796)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	427	(110,992)	0	0	0	0	0	0	0	0	0	(110,565)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,751	0	0	0	0	0	0	0	0	0	15,751	19
20	Fees, Subscriptions & Promotions	(3,188)	831	0	0	0	0	0	0	0	0	0	(2,357)	20
21	Clerical & General Office Expenses	146	20,493	0	0	0	0	0	0	0	0	0	20,639	21
22	Employee Benefits & Payroll Taxes	0	6,366	0	0	0	0	0	0	0	0	0	6,366	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,120	0	0	0	0	0	0	0	0	0	2,120	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,164	0	0	0	0	0	0	0	0	0	1,164	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(2,615)</b>	<b>(64,267)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(66,882)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(8,530)</b>	<b>(58,151)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(66,681)</b>	<b>29</b>



Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$		100.00%	\$ 573	\$ 573	1
2	V	6 Maintenance				5,543	5,543	2
3	V	17 Administrative	139,980			28,988	(110,992)	3
4	V	18 Directors						4
5	V	19 Professional Services				15,751	15,751	5
6	V	20 Fees, Subscriptions, Promotions				831	831	6
7	V	21 Clerical				20,493	20,493	7
8	V	22 Employee Benefits	3,000			9,366	6,366	8
9	V	23 In-Service						9
10	V	24 Travel and Seminar				2,120	2,120	10
11	V	26 Insurance				1,164	1,164	11
12	V	30 Depreciation				6,364	6,364	12
13	V							13
14	Total		\$ 142,980			\$ 91,193	\$ * (51,787)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number      Pleasant Meadows Christian Village      #      0019166      Report Period Beginning:      July 1, 1999      Ending:      June 30, 2000

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 1999 Ending: ne 30, 2000

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number (\_\_\_\_) \_\_\_\_\_  
 Fax Number (\_\_\_\_) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	This worksheet is not applicable				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Pleasant Meadows Christian Village # 0019166 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related							\$	\$			\$	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related							\$	\$			\$	14
15	TOTALS (line 9+line14)							\$	\$			\$	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	This W/P NA	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8		
	1996	9		
	1997	10		
	1998	11		
	1999	12		

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

A. Square Feet: 37,000

B. General Construction Type: Exterior Brick Frame Steel

Number of Stories 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	435,600	1971	\$ 15,876	1
2	Home Office Allocation			5,459	2
3	TOTALS	435,600		\$ 21,335	3

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning:

July 1, 1999 Ending: June 30, 2000

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1975	1975	\$ 1,305,939	\$ 30,697	40	\$ 32,648	\$ 1,951	\$ 774,975	4
5			1975	1975	228,890		20				5
6			2000	2000	1,235,805	20,597	30	20,597		20,597	6
7											7
8	Home Office				38,952	1,272		1,272		16,911	8
	<b>Improvement Type**</b>										
9	Land Improvements		1975		12,878		20			12,878	9
10	Land Improvements		1978		5,737		20			5,737	10
11	Building Improvements		1979		3,855	84	46	84		1,806	11
12	Building Improvements		1980		533	12	44	12		240	12
13	Land Improvements		1981		597		10			597	13
14	Building Improvements		1981		917	21	43	21		408	14
15	Building Improvements		1982		20,257	1,013	20	1,013		18,740	15
16	Land Improvements		1984		10,350	57	15	57		10,350	16
17	Land Improvements		1984		4,779	239	20	239		3,784	17
18	Contractor A/C		1985		4,298	280	15	280		4,298	18
19	Shrubery		1986		96		10			96	19
20	Landscaping		1986		6,549	327	20	327		4,605	20
21	Sewer Repairs		1986		2,310	116	20	116		1,576	21
22	Condensing Unit A/C		1986		3,015		10			3,015	22
23	Building Improvements		1987		450		10			450	23
24	Building Improvements		1987		18,430	1,229	15	1,229		15,670	24
25	Building Improvements		1987		2,258		10			2,258	25
26	Building Improvements		1987		800	40	20	40		517	26
27	Building Improvements		1987		312	2	10	2		312	27
28	Building Improvements		1988		1,314	4	10	4		1,314	28
29	Block Shute & Structure		1988		2,725	136	20	136		1,598	29
30	Building Improvements		1988		3,234	3	10	3		3,234	30
31	Building Improvements		1988		3,250	217	15	217		2,622	31
32	Building Improvements		1988		20,978	1,399	15	1,399		16,905	32
33	Phone Lines		1989		1,193	3	10	3		1,193	33
34	Resurface Parking Lot		1989		23,325	1,555	15	1,555		17,235	34
35	Landfill		1989		919		10			919	35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 2,964,945	\$ 59,303		\$ 61,254	\$ 1,951	\$ 944,840	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning:

July 1, 1999 Ending: June 30, 2000

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Wallcovering		1989		2,957	1	5	1		2,957	9
10	Wallcovering		1990		1,594		5			1,594	10
11	Reroof Portion of NH		1990		11,305	754	15	754		7,603	11
12	Rail/Baseboard		1990		775	78	10	78		754	12
13	Wallcovering		1990		1,835		5			1,835	13
14	Wallcovering		1991		1,835		5			1,835	14
15	Wallcovering		1991		5,136	1	5	1		5,136	15
16	Rail/Baseboard		1991		744	37	20	37		345	16
17	Wallcovering		1991		848		5			848	17
18	Remodeling		1991		2,996	150	20	150		1,388	18
19	Landscaping		1991		2,721	136	20	136		1,258	19
20	Landscaping		1991		981	49	20	49		445	20
21	Water Meter		1991		500	50	10	50		454	21
22	Roof		1991		8,000	533	15	533		4,708	22
23	Remodeling		1991		1,720	86	20	86		753	23
24	Wallcovering		1991		3,854	4	5	4		3,854	24
25	Sprinkler System		1991		602	40	15	40		343	25
26	Remodeling		1992		5,488	275	20	275		2,346	26
27	Remodeling		1992		6,610	331	20	331		2,775	27
28	Carpeting		1992		4,115		5			4,115	28
29	Trees		1992		600	30	20	30		242	29
30	Carpeting		1992		8,647	2	5	2		8,647	30
31	Door		1992		551	37	15	37		296	31
32	Roof		1992		11,500	767	15	767		6,008	32
33	Carpeting		1992		806	1	5	1		806	33
34	Wallcovering		1992		3,384		5			3,384	34
35	Wallcovering		1993		3,081	1	5	1		3,081	35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 93,185	\$ 3,363		\$ 3,363	\$	\$ 67,810	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning:

July 1, 1999 Ending: June 30, 2000

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	E-Z Barn			1993	1,891	126	15	126		899	9	
10	Carpeting			1993	5,093		5			5,093	10	
11	A/C System			1993	11,333	756	15	756		5,355	11	
12	Sink			1993	2,199	220	10	220		1,558	12	
13	Landscaping			1993	2,000	100	20	100		700	13	
14	Roof-NE/Gutters			1993	15,680	1,045	15	1,045		7,228	14	
15	Gutters			1993	990	66	15	66		446	15	
16	Baseboard/Wallcoverings			1993	9,755	5	5	5		9,755	16	
17	10 Ton A/C Unit			1994	9,817	654	15	654		3,978	17	
18	Roof Hall			1994	9,600	640	15	640		3,733	18	
19	Roof Top			1994	15,088	1,006	15	1,006		5,868	19	
20	Gutters			1994	934	93	10	93		535	20	
21	Rooftop A/C			1994	44,062	2,937	15	2,937		16,643	21	
22	Tile Bathrooms			1995	673	65	5	65		673	22	
23	Dining Room Lights			1995		200	10	200			23	
24	Kitchen Exhaust Fan			1995	1,680	168	10	168		865	24	
25	Rooftop A/C			1995	7,197	720	10	720		3,720	25	
26	Bathroom Motion Light			1995	7,299	730	10	730		3,772	26	
27	Ceramic Tile shower			1995	7,546	755	10	755		3,838	27	
28	Skylight Dining Room			1995	6,785	679	10	679		3,338	28	
29	Fire Alarm			1995	1,222	122	10	122		580	29	
30	Wallcoverings			1996	3,300	660	5	660		2,970	30	
31	Fire Alarm			1996	17,700	1,770	10	1,770		7,523	31	
32	Termite system			1996	11,000	220	20	220		1,962	32	
33											33	
34	Landscaping			1996	1,000	200	5	200		783	34	
35	Gutters			1996	6,258	626	10	626		2,295	35	
36	TOTAL (lines 4 thru 35)				\$ 200,102	\$ 14,563		\$ 14,563	\$	\$ 94,110	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning:

July 1, 1999 Ending: June 30, 2000

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Kick plates	1997		2,743	274	10	274		959	9
10		Wallcoverings	1997		3,290	658	5	658		2,303	10
11		Energy Management System	1997		15,018	1,502	10	1,502		4,756	11
12		Ventilation Fan	1997		2,167	217	10	217		633	12
13		Resurface Parking lot	1997		6,000	2,000	3	2,000		5,667	13
14		Wallcoverings	1998		8,455	1,691	5	1,691		4,087	14
15		Rubber Roof Skylight	1998		3,100	620	5	620		1,395	15
16		Floor-Therapy room	1998		972	194	5	194		404	16
17		Water Heater	1999		4,139	414	30	414		552	17
18		Fire Dampers	1999		7,952	795	10	795		1,060	18
19		Alarm System	2000		1,152	115	10	115		115	19
20		Quarry Tile	2000		2,033	339	5	339		339	20
21		Deck	2000		1,271	21	5	21		21	21
22		Gazebo	2000		6,274	627	10	627		627	22
23		Fencing	2000		3,610	361	10	361		361	23
24		Landscaping	2000		9,303	620	10	620		620	24
25		Fencing	2000		2,200	110	10	110		110	25
26		Flowers	2000		705	12	10	12		12	26
27		Flowers	2000		833	14	10	14		14	27
28		Garage	2000		19,001	475	40	475		475	28
29		Shed	2000		1,510	38	10	38		38	29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 101,728	\$ 11,097		\$ 11,097	\$	\$ 24,548	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 271,146	\$ 28,059	\$ 28,059	\$	Various	\$ 393,471	37
38	Current Year Purchases	111,748	6,277	6,277		Various	6,277	38
39	Fully Depreciated Assets	244,642				n/a		39
40	Home Office	33,999	3,509	3,509			27,644	40
41	TOTALS	\$ 661,535	\$ 37,845	\$ 37,845	\$		\$ 427,392	41

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transport	1994 Ford Bus	1994	\$ 43,500	\$ 5,438	\$ 5,438	\$	8	\$ 33,534	42
43										43
44										44
45	Home Office Allocation			7,404	1,582	1,582			2,282	45
46	TOTALS			\$ 50,904	\$ 7,020	\$ 7,020	\$		\$ 35,816	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 4,093,734	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 133,191	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 135,142	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 1,951	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,594,516	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Independent Living Unit	\$ 426,693	\$ 13,056	\$ 168,806	52
53	Independent Living Unit	21,848	322	20,802	53
54	Apartments	94,760	3,159	59,914	54
55	Apartment Equipment	1,120	127	414	55
56	Land	24,818			56
57	TOTALS	\$ 569,239	\$ 16,664	\$ 249,936	57

G. Construction-in-Progress

	Description	Cost	
58			58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**If NO, see instructions.**

☐ YES      ☐ NO

## Ending

14. \_\_\_\_\_ /2003 \$ \_\_\_\_\_

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION:  IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>97</u>	3. CLINICAL PORTION:  IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE <u>42</u>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	
2	Books and Supplies		644		644
3	Classroom Wages (a)				
4	Clinical Wages (b)	738	6,663		7,401
5	In-House Trainer Wages (c)		9,685		9,685
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		1,144		1,144
9	TOTALS	\$ 738	\$ 18,136	\$	\$ 18,874
10	SUM OF line 9, col. 1 and 2 (e)	\$ 18,874			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	22
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	16
2. From other facilities (f)	
TOTAL TRAINED	22

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist		hrs	\$ This W/P is NA		\$	\$		\$	#VALUE!	1				
2	Licensed Speech and Language Development Therapist		hrs								2				
3	Licensed Recreational Therapist		hrs								3				
4	Licensed Physical Therapist		hrs								4				
5	Physician Care		visits								5				
6	Dental Care		visits								6				
7	Work Related Program		hrs								7				
8	Habilitation		hrs								8				
9	Pharmacy		# of prescripts								9				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10				
11	Academic Education		hrs								11				
12	Exceptional Care Program										12				
13	Other (specify):										13				
14	TOTAL			\$		\$	\$		\$	#VALUE!	14				

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 91,408	\$	1
2	Cash-Patient Deposits	4,186		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 28,392 )	637,427		3
4	Supply Inventory (priced at FIFO )	18,130		4
5	Short-Term Investments	396,877		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Int Rec</u>	6,333		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,154,361	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,694		13
14	Buildings, at Historical Cost	3,737,778		14
15	Leasehold Improvements, at Historical Cost	104,682		15
16	Equipment, at Historical Cost	694,000		16
17	Accumulated Depreciation (book methods)	(1,797,616)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,020,627		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Bond Costs</u>	16,495		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 3,816,660	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,971,021	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 44,636	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,186		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	112,417		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 161,239	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 161,239	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 4,809,782	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,971,021	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,261,910	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,261,910	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	547,872	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 547,872	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,809,782	24 *

\* This must agree with page 17, line 47.

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Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning: July 1, 1999

Ending: June 30, 2000

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,592,394	1
2	Discounts and Allowances for all Levels	(497,717)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,094,677	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	(427)	12
13	Barber and Beauty Care	23,451	13
14	Non-Patient Meals	57	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	307	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 23,388	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	447,472	24
25	Interest and Other Investment Income***	100,492	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 547,964	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Unrealized G/(L) - Sale of Equip &amp; Investment</b>	(36,374)	28
28a	<b>Residential &amp; Congregate</b>	193,929	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 157,555	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,823,584	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	771,717	31
32	Health Care	1,547,159	32
33	General Administration	640,899	33
	<b>B. Capital Expense</b>		
34	Ownership	127,079	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	19,886	35
36	Provider Participation Fee	57,232	36
	<b>D. Other Expenses (specify):</b>		
37	Congregate	111,740	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,275,712	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	547,872	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 547,872	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number Pleasant Meadows Christian Village

# 0019166

Report Period Beginning: July 1, 1999

Ending:

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## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,486	1,612	\$ 50,985	\$ 31.63	1
2	Assistant Director of Nursing	72	78	1,771	22.71	2
3	Registered Nurses	13,316	14,444	273,409	18.93	3
4	Licensed Practical Nurses	21,899	23,755	327,882	13.80	4
5	Nurse Aides & Orderlies	70,890	76,897	660,033	8.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,875	3,119	33,301	10.68	9
10	Activity Assistants					10
11	Social Service Workers	6,408	6,951	64,144	9.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,292	19,842	159,754	8.05	15
16	Dishwashers					16
17	Maintenance Workers	2,674	2,901	40,149	13.84	17
18	Housekeepers	9,540	10,348	82,311	7.95	18
19	Laundry	6,357	6,896	56,622	8.21	19
20	Administrator	1,650	1,790	73,364	40.99	20
21	Assistant Administrator					21
22	Other Administrative	1,147	1,244	10,895	8.76	22
23	Office Manager	1,808	1,961	31,653	16.14	23
24	Clerical	1,721	1,867	14,181	7.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	1,932	2,096	19,293	9.20	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,796	1,948	18,561	9.53	33
34	TOTAL (lines 1 - 33)	163,863	177,749	\$ 1,918,308 *	\$ 10.79	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	146	\$ 7,714	1.3	35
36	Medical Director	24	1,800	9.3	36
37	Medical Records Consultant	42	1,747	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	85	1,664	10.3	39
40	Physical Therapy Consultant	275	24,420	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	677	9,356	10.3	43
44	Activity Consultant				44
45	Social Service Consultant	60	3,247	11.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,309	\$ 49,948		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)**

[illegible]

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Robert Vincent	Administrator	0	\$ 73,364	Workers' Compensation Insurance	\$ 61,932	IDPH License Fee	\$	
				Unemployment Compensation Insurance	3,000	Advertising: Employee Recruitment	26,958	
				FICA Taxes	140,194	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	59,070	Dues/Fees	4,561	
				Employee Meals		Subscriptions	461	
				Illinois Municipal Retirement Fund (IMRF)*		Software Support	1,568	
				Employee Expense	7,626	Various	300	
				Employee Physicals	720	Promotion		
				Worker's Comp Medical Expense	1,375	Home Office Allocation	831	
				Related Party	(3,000)	Less: Public Relations Expense	(	
						Non-allowable advertising	(	
				Home Office Allocation	9,366	Yellow page advertising	(	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,364	TOTAL (agree to Schedule V, line 22, col.8)	\$ 280,283	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 34,679	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management fee			\$ 139,980			\$	Out-of-State Travel	\$ 220
							In-State Travel	2,381
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 139,980					
C. Professional Services							Seminar Expense	2,398
Vendor/Payee	Type		Amount					
Booth & Little	Legal fees		\$ 671				Travel Admin	2,032
Aaron Warnick	Chapel Services		50				Home Office Allocation	2,120
							Entertainment Expense	(
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 9,151
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 721	TOTAL		\$		

**\* Attach copy of IMRF notifications**

**\*\*See instructions.**

Facility Name & ID Number Pleasant Meadows Christian Village

STATE OF ILLINOIS

# 0019166

Report Period Beginning: July 1, 1999

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. LSN--\$4209.99
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 109
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,143 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. n/a
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over n/a
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 57,232  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ n/a Has any meal income been offset against related costs? Yes Indicate the amount. \$ 57
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? \_\_\_\_\_  
Firm Name: Eck, Schafer & Punke, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. It will be provided upon completion.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.